COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PHARMACY TAC

October 28, 2020
1:00 P.M.
(All Participants Appeared Via Zoom or Telephonically)

APPEARANCES

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CHAIR

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(Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

AGENDA

1. Payment methodology model

   *What we don't want:
   Any Clawbacks
   No add-on fees (have no basis behind them)

   *What we do want:
   No audit clauses like chain drug stores have
   Total transparency of pricing and any fee charged to pharmacy providers

2. Reimbursement Clinical Programs
   *Tobacco Cessation
   *Diabetic Education
   *Lifestyle Weight loss Coaching
   *Cognitive Function Evaluation

3. Philip Almeter: Presentation on data regarding current reimbursement rates with MCOs

4. Rosemary Smith: White Paper presentation

5. Samples of payment methodology models: attachments
   *CMS: NADAC Pricing
   *West Virginia Model
   *2020 Cost-of-Dispensing Study

6. PTAC coming to consensus on Medicaid Pharmacy Reimbursement Model

7. Next meeting date and items to be discussed

8. Adjourn

CHAIRMAN POOLE: The first item that I had was the payment methodology model, just breaking it down of what we don't want and what we do want.

And I will say that per discussions outside of our PTAC with other pharmacy individuals that has had meetings with CMS and Jessin and Commissioner Lee is that it seems like the clawbacks, fees and no additional fees and even the audit - we already have an audit law in place - but I was still going to allow Jill to make comments on this. So, go ahead, Jill.

MS. McCORMACK: Thanks, Ron. I just wanted to underscore that as we had planned on talking about clawbacks and add-on fees that Senate Bill 50 does contain two clauses that I sent out on Page 3 of the bill, Subsection (b)(i)(ii).

It says reducing payment for pharmacy or pharmacist services, directly or indirectly, which covers the DIR issue, under a reconciliation process to an effective rate of reimbursement. This prohibition shall include without limitation creating, imposing, or establishing direct or indirect renumeration fees, generic effective rates, dispensing effective rates,

brand effective rates, any other effective rates, in-network fees, performance fees, pre-adjudication fees, post-adjudication fees, or any other mechanism that reduces, or aggregately reduces, payment for pharmacy or a pharmacist services.

And, then, (ii) is, again, prohibiting creating, modifying, implementing, or indirectly establishing any fee on a pharmacy, pharmacist or a Medicaid recipient without first seeking and obtaining written approval from the department to do so.

So, Ron, I just kind of wanted to underscore that as we're talking about that, those should cover it. I think it's a matter of enforcement but happy to take any other comments on it.

DR. ALMETER: This is Philip here. I'd like to emphasize I agree 100% with that from the hospital side.

CHAIRMAN POOLE: And I agree with Jill. I just want to make sure, and I understand with other pharmacy stakeholder meetings with the Medicaid office, that all these things have been considered. Obviously, the ones you just read are in SB 50.

So, is there any more discussion, then, on I guess the provisions or terms of SB 50 concerning these topics? If not, I will move on to Dr. Almeter.

MS. HUGHES: Ron, just to let you know, Meredith and Matt have joined. And, Matt, if you could turn your video on, please.

CHAIRMAN POOLE: Okay. Thank you. Go ahead and share your comments, Dr. Almeter, please.

DR. ALMETER: This is regarding the MCO reimbursement. So, I knew a lot of discussion around moving to the single PBM for all has been around a payment model with NADAC pricing.

From a health system that has retail and specialty, we currently don't participate in a model with that. And, so, I wanted to get some feedback on what that would look like for health systems that participate in those, you know, 340B.

And, then, I also did some research checking in with the University of West Virginia to see their comments on that model.

And every way I can look at it, it looks like a promising model. Just in case we go this direction, I support that in comparison to

current reimbursement rates from the MCOs as it stands today. Just from looking at all the different angles, that seems like the most comparable rate.

Sorry. Did somebody say something?

CHAIRMAN POOLE: No, sir. That was the feedback that I've been worried about.

DR. ALMETER: So, the one other thing I would like the group to consider to put out there is I think at some point, we're going to discuss the cost-of-dispensing study, and I think that's important because the current dispensing fee, at least with fee-for-service at $10.64, might not be up to market per that study.

And I would argue that in the world of specialty pharmacy, that there would be a consideration for an enhanced dispense fee because a significant PA (inaudible) benefits investigation where you start teaching clinical documentation, whole chain distribution as well as whole chain distribution testing and validation, the actual cost is much higher. I think the study referenced $75.

In talking to other health systems that do this, they think it might be closer to $100, and I think that study may have included

some large, big-box specialty pharmacies that have a much larger operation.

That's just one other thing I think the group should consider in looking at dispense fees with specialty products. Those are the comments I wanted to add. Any questions on those?

MR. CARRICO: No questions. This is Matt. I want to back up what you said. I think there's three areas that need to be considered different dispensing fees rather than just NADAC plus $10.64, specialty being one of them.

I'm not a specialty pharmacy but I called a couple. And even though the bill says you don't have to be a "specialty" pharmacy to dispense, they still have to be for everyone else. So, the cost is still there, and it sounds like it's a bunch of red tape and it's not cheap to do.

And, to be honest, if I was a specialty pharmacy and dispensed a $15,000 medicine and got $10.64, I would wonder why I'm a specialty pharmacy.

But specialty is one of them, compounding is another and, then, vaccines are another as well. And I might be jumping ahead. However, with this said, if we're trying to get

something in place before July 1st, my rough idea is to go ahead and try to get like a NADAC plus $10.64 or whatever we agree on for across the board to get implemented ASAP before July 1st, and once we get that date figured out, see if we can perform a cost of dispensing for specialty, compounding and immunizations to hopefully be into effect by July 1st; but in the meantime, we stop the bleeding with all the other stuff. I'm just throwing that out there.

MS. McCORMACK: Hi. This is Jill McCormack. The study that I sent out a week or two ago that CPA and CVS did together, that does include a study of specialty pharmacy. It's on Page 26 of the document.

MR. CARRICO: What day did you send that out?

MS. McCORMACK: I'm happy to re-send it to the group.

MR. CARRICO: And you said Page 27?

MS. McCORMACK: It's Page 26 of the actual document, Page 32 of the PDF. I'm sorry. Yes, that's right.

CHAIRMAN POOLE: Jill, do you

mind to hit the high notes on that? I've got so many reports and everything in front of me, that's one I might not have.

MS. McCORMACK: I apologize. I'm kind of looking at this for the first time and it looks like the cost of dispensing for specialty drugs, the mean is $24.63. And, then, of course, we go through the mean, the ST, 50th percentile out of median, the 75th percentile and the 95% percentile, the highest being 74 to 76 and the mean being $24.63.

MR. CARRICO: And is that for all pharmacies or chain pharmacies?

MS. McCORMACK: All pharmacies that responded to the survey and the final analytical sample that was reported to the analyzers.

DR. ALMETER: So, I have a comment. When I spoke to WVU, they calculated their cost to be, depending on the drug, somewhere between $100 and $125 to dispense, and they felt that that study presents a large data set that the large mail order pharmacies that are more vertically aligned like Accredo, CVS Specialty, etcetera, may have skewed the data because they have large, big-box operations in Orlando, Phoenix, Indianapolis, Memphis. They have the ability to leverage economies

of scale and reduce costs to dispense.

So, I think speaking to other academic medical centers that have done this work, without having a large operation like that, it is more costly.

MS. McCORMACK: Obviously, we would have to read the study and see what the limitations of the study were. I just wanted to let you know that there is something out there.

CHAIRMAN POOLE: Well, Jill, what year or what is the date they're pulling their data from?

MS. McCORMACK: This is the 2019 Cost-of-Dispensing Study. Sorry, guys. This is like 100 pages long.

DR. FIGG: I believe the data is from 2018.

MS. McCORMACK: Yes. So, it must be based on 2018 data.

DR. FIGG: I think it mentions that this is the first national survey of cost of dispensing on specialty drugs and it kind of outlines a lot of the difficulty in trying to kind of nail some of that down because of the definition of specialty drug, what is that. There's definitely

some that the dispensing is much cheaper and the requirements that go on with that are less time-consuming. So, I think when you talk about specialty drugs, you have to consider that it's kind of all over the place.

And to Philip's point, you're talking about drugs that require recommendations and restrictions all over the place and you're talking about the providers that are providing for this being big-box and small. So, it's really all over the place as far as what the reimbursement would be because of the different requirements on each drug.

CHAIRMAN POOLE: I think just like on the 2020 Cost-of-Dispensing Study that I provided you all prepared by Abt Associates and the NPI Group that was commissioned by NACDS, NCPA and National Association of Specialty Pharmacy, those figures in that study, the mean specialty drug costs were $73.58 and the range was from $40.12 up to $86.48.

So, I think that proves your point that these particular evaluations can be moving a lot more than your standard book of business.

So, I don't think Matt has got a bad idea that if we can get the program started and

to try to, then, possibly even work with our own specialty drug pharmacies inside the state to come up with some figures and hopefully be able to adjust those figures to help those people out.

Does anybody have any further comment on what Philip started with his comments? If not, I will let Rosemary take over with her presentation. We're going to come back to a lot of these topics. Anybody have anything else? Okay. Rosemary, would you like to go ahead?

MS. SMITH: Thank you, Ron. I had sent out a White Paper and some other information to all the members, but I thought I might quickly go through a time line of where we are.

I think we all know in the second term of Governor Steve Beshear Administration that 80% of our Medicaid population was moved under managed care, and the State then contracted with Managed Care Organizations who then subcontracted to Pharmacy Benefit Managers.

So, the initial contractual arrangement created problems because the State had no contractual oversight over PBM's. As a result other than when impeded by legislation actions, PBM's have been allowed to manage $1.7 billion of solely

taxpayer dollars with no oversight or regulation.

In 2013, the Legislature passed Senate Bill 107 simply saying that PBMs had to tell pharmacists how much they would pay for a drug before it was dispensed. After that bill passed, the PBMs refused to comply.

As a result, in 2016, the Legislature passed Senate Bill 117 that allowed the Department of Insurance to adjudicate complaints from pharmacists if PBMs were operating in violation of the law.

PBMs refused to comply with state law and Kentucky DOI issued a $1.5 million fine and license suspension to CVS Caremark based on over 400 violations of state law within six months. DOI later settled with CVS Caremark allowing them to pay the fine but removing the suspension.

Based on their current profit margin, it arguably took CVS Caremark less than a week's worth of revenue generated in Kentucky to pay the fine.

So, in 2018, the Senate passed by a 32-to-4 margin a carve-out of pharmacy benefits, therefore, ending the PBM experiment in Kentucky, but CHFS said they could not operate under a pharmacy

carve-out and they worked with pharmacists on legislation that would give the CHFS full power to police PBM activity which passed instead of the carve-out. To date, CHFS has largely not implemented the bill they suggested.

In February of 2019, nine months after it was mandated to do so by law, CHFS released the report titled Medicaid Pharmacy Pricing - Opening the Black Box showing PBMs took a minimum spread of $123 million out of Kentucky's $1.7 billion pharmacy spend.

By CHFS' own admission, this was not a complete number. WellCare, with 39% of the managed care population, refused to comply with the state law mandated data request and reported zero dollars in spread. The $123 million represents the number for the other MCOs and PBMs.

Some Cabinet officials and actuaries stated then that they believed the real profit number was closer to $250 million. And just $123 million, that represents over $335,000 in profits PBMs take out of local communities and keep for themselves every day.

On November 22, 2019, nine months after CHFS released their Black Box report

showing the spread of $123 million without any data from WellCare, CHFS released their preliminary feasibility study of a pharmacy carve-out model.

A report showed a net estimated impact of the pharmacy carve-out to be $237.5 million. The net savings figure was in line with the projections taking the Black Box report and added the WellCare data.

In April of this year, as we all know, the Legislature passed Senate Bill 50 which is the focus of our committee today.

So, PBMs in my opinion have been unable to show any quantitative savings to Kentucky for the services they performed.

Based on the most conservative numbers, PBMs have profited more than $1 billion in strictly taxpayer funds since managed care began in Kentucky, and they did this not by reducing spending to the State or improving the quality of care. They did it simply by transferring the $1 billion that used to go back to Kentucky communities to themselves.

There is an independent pharmacy in 119 of 120 counties. My group, KIPA, represents those over 500 independents. In some

rural counties, there is only an independent pharmacy. In the last two years, over forty of those local small businesses have closed only as a result of Medicaid's lack of action to control this arbitrary PBM behavior.

The main problems with PBMs lie on changes to state contracts and federal oversight. The Trump Administration has launched an investigation into PBM activity.

That said, the temporary solution to keep pharmacies from continuing to close is to transfer the identified at least $237.5 million from the PBM profits back to local community pharmacies by our higher dispensing fees.

As Matt has already talked about and we've all discussed, CMS currently recommends the $10.64 dispensing fee per drug, per prescription. That is what CMS says is the break-even point for pharmacies.

Kentucky averages a $2.80 dispensing fee. And as we all know, $2 of that came from the Legislature and their budgeting. PBMs pay on an average eighty cents in dispensing fees, less than 10% of what the federal government recommends.

This isn't about pharmacists

wanting higher fees for higher profits. It's a matter of keeping $237.5 million in taxpayer dollars in Kentucky communities instead of sending it out to out-of-state PBMs who have repeatedly refused to comply with state law.

One very important point that wasn't addressed in the latest report is that another $200 million would be infused back into the communities you serve in the form of the increased professional dispensing fee going from $2.80 on average to $10.64 per Rx. In fact, a pharmacy carve-out would have infused approximately $437.5 million back into our state.

So, I think just looking at the White Paper that I sent, just to go over it just quickly, there are twelve states that did not go to managed care and they all have very comparable fee-for-service fee ranges.

There are eight states that did go to managed care - Iowa, Kansas, Louisiana, Mississippi, Nebraska, New Mexico, North Dakota, and Tennessee. They all are managed care but they dictate that fee-for-service is also how they will be paid. They are being paid the same rate as fee-for-service.

I think all of us know that California, the State of California on January 1st is carving pharmacy out of their Medicaid benefits for managed care and it will move thirteen million Medi-Cal beneficiaries back to fee-for-service. Their dispensing fee there is $13.20.

Michigan is the latest state that has moved - the Governor said on December 1st that they're moving the pharmacy benefits out of managed care back to fee-for-service methodology.

April of 2021, New York will move pharmacy benefits for 4.3 million Medicaid managed care members back to fee-for-service.

And as Ron and Philip have already talked about, West Virginia was the first state that carved pharmacy out.

So, I think we're sitting and I agree with Matt and Philip that we are in a crucial time here for pharmacies, not only independents but I'm sure chains as well, and I think Jill would probably agree with that; but I think we're at a point that we really need to consider working together, working with the Medicaid Department and doing this as quickly as possible so we can get an implementation of a new payment methodology.

CHAIRMAN POOLE: Thank you, Rosemary.

MS. HUGHES: Rosemary, could you send me a copy of that?

MS. Smith: Yes, I will.

MS. HUGHES: Thank you.

CHAIRMAN POOLE: I think that was a very good chronological order of how things have evolved to this point.

One thing that I've learned through some of the conversations of other stakeholders with the Medicaid Department is these cost-of-dispensing studies, we used to have to do them in the nineties just to set the Medicaid rate, and Myers & Stauffer is the ones who got the contract to do that.

And when every year they started showing more and more increases because the cost fo everything is going up, they kind of did away with that methodology.

So, Matt alluded to at our last meeting, and I can assure you I've already ran my reports also, that the first - you can look at what you were getting reimbursed ten to twelve months ago versus the same book of business now and it is a

double-digit reduction, and in some cases a 20% reduction and more.

So, we've got some people out there that are hurting and struggling and still taking care of Medicaid patients, and I just would like to reiterate to the Medicaid Department on the call is that these are real figures.

The one cost-of-dispensing study that encompassed 2018 data, the cost of dispensing was $12.40, and I just remind people of the title of it. All of us who are in the trenches know that that's just the cost of dispensing. Profit is not a bad word but profit is not a part of that equation.

This law came into effect because legislators have heard us and we're trying to get to a consensus here. I know legislators are still asking me every time we have a meeting as to what's going on because they're wanting to get this implemented a whole lot faster than July 1st because they hear it from all of pharmacy, not just independents. They hear it from chain. They hear it from everybody, including the hospital outpatient 340B programs.

So, with this in mind, and also

to point out, the study that I'm showing is 2018. NADAC itself is working off of figures in the past. So, we're not even looking at a current model of what the cost structure is right now.

And I can assure you that every pharmacy that's still in business - and I just lost a colleague about six months ago that had to close his doors - but I can assure you that our costs, we're about as lean as we possibly can be and our costs don't go down. And, of course, this cost of dispensing is not even considering the cost of the prescription or the drug itself.

So, just like the study shows that 58% of the $12.40 is made up of just payroll costs alone and that's taking into consideration all forms of pharmacy.

Whenever the message is being delivered by somebody that's providing the care, I'll just remind everybody that we don't have two lobbyists for every state legislator and every Congressman like PCMA does.

So, when we're providing the care, the message should be clear that we're the ones taking care of the patients and we don't have a slick team to give the presentations of how our true plight

is. We just go by what has been presented, what the cost-of-dispensing studies are done. We've got the proof of other states that have done what they've done.

So, me personally, I feel that the Medicaid Program should be working with us to get this accomplished and actually be excited to, when the first numbers come out about how much they're saving the State, to be touting the fact that they're responsible stewards of taxpayer dollars.

Anyhow, I didn't know if at this particular time - the only thing I want to mention is the reason why I put the reimbursement of clinical programs on there is because obviously every association, every organization such as UK - UK has worked great with all of pharmacy and working programs to save Medicaid money and to take better care of patients.

And I don't want this to get lost in this situation because there's other states doing simple things that is showing cost savings. Like, Ohio and Pennsylvania are doing a program through Medicaid that on every antibiotic that is dispensed, there is a follow-up, and they're paying for that follow-up and that follow-up is actually

rendering better outcomes and saving some money.

So, I just don't want that to fall through the cracks because there's a lot of programs out there that pharmacists are doing every day in Kentucky and can save the program money and it's been proven. There's actually years and years of clinical data out there to prove it.

So, that's something that I'd really like for the committee to work on in the future to work with the program on certain areas of the state to be able to do pilot programs to show the benefits and hopefully get some reimbursement models going on that.

So, anyway, I didn't know if Matt or anybody or Rosemary wanted to further comment on things or make a motion.

MS. SMITH: Ron, I would make a motion that our Kentucky DMS to request that CMS approve the federally-recommended fee-for-service dispensing fee rate for Kentucky Medicaid prescriptions filled either under managed care or fee-for-service.

Included in this motion is that DMS send the request to CMS in a timely manner since Senate Bill 50 requires the Cabinet set reimbursement

rates to be used in conjunction with the single state PBM.

DR. FIGG: I'd like to second that. I think if fee-for-service already has $10.64, us putting that forward is probably the easiest lift to get this approved as quickly as possible through CMS and I think that's what we'd all like to see is some movement.

CHAIRMAN POOLE: Rosemary, do you feel that we need to put an addendum on your motion of what Matt said, looking at other not just standard pharmacy but looking at specialty pharmacy compounding and 340B to work out those----

DR. ALMETER: Vaccination.

CHAIRMAN POOLE: ----as we get going with the program? Go ahead, Philip.

DR. ALMETER: I think it was vaccinations - compounding, specialty and vaccinations.

CHAIRMAN POOLE: Okay. Thanks.

MS. SMITH: Right. Absolutely. Yes, I'd like to add that to the motion.

CHAIRMAN POOLE: Would you second that, Meredith?

DR. FIGG: Yes.

CHAIRMAN POOLE: I've got a motion by Rosemary and a second by Meredith. Any further discussion?

MS. McCORMACK: I have a question, Ron. I assume, based on the context, that we're talking about a single rate across all pharmacies; but if we need to clarify that by putting the word single, I would appreciate that, and I'm for the motion.

MS. STRAUB: This is Paula. I just want to confirm we're talking NADAC plus a dispensing fee, right, the dispensing fee of $10.64?

MS. SMITH: Yes.

MS. STRAUB: Okay. I'm just confirming that.

CHAIRMAN POOLE: That was what her motion was. Any further discussion?

DR. ALMETER: I just wanted to add one comment that you said earlier, Ron, that I second wholeheartedly. Since the Board of Pharmacy approved "x" many protocols, I know you have four reimbursement for clinical programs right here, but there's so many more opportunities, and the accessibility of our pharmacists in the community is huge.

And if going to a pharmacy that offers, say, like a Strep test, that's one less visit to an M.D. That's going to cause less cost to the system. It would be nice if Medicaid could look at that because we are looking at - we're working with the College of Pharmacy and Trish Freeman trying to figure out how can we implement some of these things.

We're at a point now where we can do it but will we get paid? And, so, we want to approve it so we can get paid, but there is evidence out there already that this works. We just haven't really done it in Kentucky as much. I'm fully supportive of that.

CHAIRMAN POOLE: Okay. Rosemary, would you just-----

MS. SMITH: I agree.

CHAIRMAN POOLE: Just put the addendum on there - in addition, looking into protocol models that are already existing in the state and already been developed to work with the Medicaid Program either in a pilot study or a study to be able to find different clinical interventions pharmacists can do to save the state money and to improve the quality of patient care and improve patient outcomes.

MS. SMITH: Absolutely.

DR. ALMETER: I'm sorry. I have one more thing I wanted to add on. With the NADAC pricing, my understanding is in the specialty world and talking to other colleagues that live in there, about 80% of specialty items don't have a NADAC price. And my understanding of their program is that that will default to the WAC price.

I'm supportive of that. I just wanted to make sure that we're clear on that. If we're saying moving to NADAC, that with NADAC prices not existing, it would be WAC.

CHAIRMAN POOLE: Okay. Rosemary?

MS. SMITH: Yes, we could definitely add that.

CHAIRMAN POOLE: Add that terminology in there.

MS. SMITH: Yes.

CHAIRMAN POOLE: If you don't mind, Rosemary, you and I can stay on the line when our meeting is over and help Sharley to get the proper language of the motion and you and I can work on that and make sure she has got a complete version of it and what was passed. Okay?

MS. HUGHES: Ron, you need to do that during the meeting. With the open meeting laws, we do have to work on that during the meeting.

CHAIRMAN POOLE: Okay. Rosemary, do you have something written on your motion?

MS. SMITH: I just have part of the motion.

CHAIRMAN POOLE: Do you either want to work on it there or forward it to me and let me work on it and we can take like a five-minute break or just everybody stay on the line until I can get something in final form, or if you want to try to restate it and it will be recorded, including all the things that we had added on.

DR. ALMETER: Can I ask one more question? Sorry.

MS. McCORMACK: I had one, too.

CHAIRMAN POOLE: Yes.

DR. ALMETER: So, just so we're clear, we discussed at the very beginning of this about the clawbacks, DIR fees, add-on fees as already being a part of Senate Bill 50 and that will be part of this.

One thing that is not included

in Senate Bill 50 is copay accumulators. We never mention that in Senate Bill 50. There was a House bill about this but it kind of died in committee, but I know our patients, when they get a copay card or a coupon and having that not count as their deductible, it hurts them.

So, I don't know if that is something we can add to this, that we would say since this is the State Medicaid, we would want to prevent copay accumulators from going on. I don't know how the group feels about that but I thought that was something worth mentioning.

MS. McCORMACK: I don't know much about that issue and I don't know if that's in our charge but I'm happy to talk about it.

DR. ALMETER: It's currently something that many PBMs do today. So, say you have a $100 copay and there's a coupon or a copay card that allows you to get that for half off and you pay $50, the PBM will only say you met $50 of your deductible. Basically, it takes patient assistance and doesn't allow it to be counted towards your deductible.

MS. McCORMACK: I'm happy to talk about issues that help patients. I'm just not

sure that that's part of our charge here but I'd be happy to hear from others, but I don't think it's relevant in Medicaid, so, I don't think there are already copays, at least on the retail side.

DR. FIGG: There are small copays.

CHAIRMAN POOLE: Philip, are you seeing those be----

DR. ALMETER: So, even if you are an MCO patient today and we have a very high-dollar specialty drug, your copayment could be hundreds. It could be very high even with a Medicaid MCO.

So, I know we're talking about the new world moving forward with this, but I'm also trying to think about current state, what we're dealing with with certain high-dollar therapies for patients.

DR. JOSEPH: Philip?

CHAIRMAN POOLE: Yes, Jessin. Did you want to say something?

DR. JOSEPH: I really don't want to add too much. I'm just taking notes, guys, honestly. So, yes, I appreciate you guys all talking about this.

Phil, if you can point to me where that's occurring in the managed care realm. From my understanding, that should not be occurring due to what we've already put into the managed care contracts.

And, then, I think Jill kind of hit it on the head, though. From a federal standpoint, there can't be copay accumulators within the Medicaid and Medicare space. So, it may be a moot issue.

MR. ALMETER: If I find it, I will send it to you. I just want to make sure that it was discussed but I appreciate the discussion.

CHAIRMAN POOLE: Let me just break in for a second. Sharley, could you let Matt get back in to the meeting? He got cut off.

MS. HUGHES: Yes. I just let him in.

CHAIRMAN POOLE: Okay.

MS. McCORMACK: Ron, I have another suggestion for the reimbursement methodology language. Can we ask that CMS approve the rate as a floor so that, in the future, if there are opportunities to, if we get a new cost-of-dispensing study, there are opportunities to increase that, that

it may cause less confusion and less waiver requests if we do it as a floor?

So, NADAC plus $10.64 would be the floor and there would also be other opportunities should the managed care companies or the single PBM want to do value-based payments or other kinds of programs that we could all take advantage of if we so choose, that that option would be there, just to kind of keep from having to go through a process again in several years, hopefully.

CHAIRMAN POOLE: Rosemary, do you have your motion, the base motion in writing?

MS. SMITH: I do, base motion. Should we maybe vote on the base motion and see if that passes and, then, have an additional motion to add to it?

CHAIRMAN POOLE: I think it would be nice to go ahead and just add everything into the original motion.

MS. SMITH: Okay. First we need to include what Jill said, right? So, I said I make a motion for Kentucky DMS to request that CMS approve the federally-recommended fee-for-service dispensing fee rate for Kentucky Medicaid prescriptions filled either under managed care or fee-for-service.

So, Jill, what do we need to add in that sentence? You wanted to make sure that it was the same.

CHAIRMAN POOLE: Well, the floor is what she was talking about.

MS. SMITH: This was earlier when she was talking originally. You were talking about to make sure that the rate was across the board. Is that correct?

MS. McCORMACK: I talked about a single rate, so, single dispensing fee, meaning that all pharmacies would get paid the same but make it a floor. So, you put me on the spot wordsmithing, but would it be something like that Kentucky request that CMS approve NADAC plus $10.64, a single rate of NADAC plus $10.64 as the floor for reimbursement in the Kentucky Managed Medicaid Program.

MS. SMITH: I think we need to say either the managed care or fee-for-service, right?

MS. McCORMACK: Well, a fee-for-service rate is already approved, correct, but we're going to have both? I'm fine with that.

DR. JOSEPH: Just semantics here. The fee-for-service program is based off of

lowest of logic. So, it's not just NADAC. So, if you say NADAC plus $10.64, then, you miss out on the other pieces.

MS. STRAUB: And I want to make sure 340B is covered in this as well. We need to make sure that all pharmacies including 340B. So, we need to make sure they're included in this language that they're a NADAC plus the dispensing fee.

DR. ALMETER: And that's important because Senate Bill 50 has a non-discriminatory clause, where a fee-for-service, all 340B savings move to the State. It doesn't exist right now in the MCO world. And, so, if you take fee-for-service and put it on the MCO claims, that's a piece that the current Senate bill says should not discriminate against 340B. That's a good point, Paula.

MS. SMITH: I think that's the reason my motion that I didn't say, Jessin, to your point, the NADAC because it is a lesser. It would just be using the federally-recommended methodology that's already in place which shows the NADAC, the WAC. You have to stay away from just saying NADAC.

DR. ALMETER: But 340B would not be included on that list because it is currently

included on that list for fee-for-service.

MR. CARRICO: Guys, there's a couple of things I wanted to mention. I'm not sure if we covered it when I got disconnected or if this is the place to bring it up, but one thing that is an issue with the way fee-for-service is now is if you get one drug, you get the dispensing fee one time that month.

So, if it's a 15-day supply and it's written twice, you're only going to get paid for the dispensing fee once. And where I work, I have a lot of nurse practitioners, a lot of two-week, one-week supplies if things are written, and I don't think it's right if we don't get a dispensing fee for each time we bill something.

The second part is are we going to be able to appeal NADAC pricing through DOI because I know a few things on fee-for-service right now where that might be the NADAC pricing but there's no place you can get it for that price. Is it going to apply the same way to this?

CHAIRMAN POOLE: Okay.

MR. CARRICO: But that one-time dispensing fee for, I don't know if it's twenty-eight days or whatever, that will be a killer for a lot of

people, especially me. So, I don't know if that gets put in now or----

CHAIRMAN POOLE: Rosemary, do you have a written copy of your original?

MS. SMITH: No. I just have it written. I don't have it on my computer. I'll text it to you.

CHAIRMAN POOLE: Let me get it to pull up here. Okay. Rosemary, if you would not mind to go ahead and dictate your motion as you know it for now and we will keep working on it. So, go ahead.

MS. SMITH: Okay. I make a motion for our Kentucky DMS to request that CMS approve the federally-recommended fee-for-service dispensing fee rate for Kentucky Medicaid prescriptions filled either under managed care or fee-for-service.

CHAIRMAN POOLE: Was that all?

MS. SMITH: No. I have: Included in this motion is that DMS send the request to CMS in a timely manner since Senate Bill 50 requires that the Cabinet set reimbursement rates to be used in conjunction with the single state PBM.

CHAIRMAN POOLE: So, read

through that one more time to make sure I got everything first.

MS. SMITH: I make a motion for our Kentucky DMS to request that CMS approve the federally-recommended fee-for-service dispensing fee rate for Kentucky Medicaid prescriptions filled either under managed care or fee-for-service.

Included in this motion is that DMS send the request to CMS in a timely manner since Senate Bill 50 requires that the Cabinet set reimbursement rates to be used in conjunction with the single state PBM.

MS. HUGHES: Ron, I have made you co-host. So, if you want to share that on the screen so that all your members can see it, that will help with everyone telling you to where they had words or not.

CHAIRMAN POOLE: Okay. Let me get all my typing done so far.

DR. FIGG: I know that this motion says a timely submission. Jessin, can you give me a time frame on how quickly we could request this approval from CMS?

DR. JOSEPH: I don't know how a time frame would work with CMS. I know we can ask

CMS what it would look like. I think just from my understanding, a preprint in any way is a 90-day turnaround time. And, so, depending on when CMS gets to it, the clock starts once we submit.

DR. FIGG: I was asking how quickly can DMS submit it to CMS.

DR. JOSEPH: I mean, as soon as we've kind of drafted it up and gotten it through. I can't give you a date, unfortunately.

The thing I would just probably add is that if it's exactly like the fee-for-service one, the work that my team would need to do is less than if it was something else. That's all I'd say in terms of the time line.

MR. CARRICO: So, Jessin, if we went forth kind of mimicking most of the parts of the current fee-for-service, is February looking like a realistic implementation if they approve it?

DR. JOSEPH: February for implementation. I don't know. I don't know because there's other factors. This is when CMS would get it, but we also need to talk to the actuaries about how this works because now the rates have changed. So, I can't say that February would make sense. I really don't know.

MR. CARRICO: And if we were to follow through with the plan of trying to get everything approved for NADAC plus dispensing fee and we wanted to follow up on cost of dispensing for specially compounding vaccines, when in your mind is the turnaround time for when we would be able to get that rolling and submitted?

DR. JOSEPH: I have it in my notes but I don't know where we came to that conclusion. My understanding of this recommendation is for DMS to submit something to be identical to the current fee-for-service methodology ASAP, and, then, the TAC was going to recommend a different cost of dispensing at a later date for compound, specialty and immunizations.

MR. CARRICO: Correct, but we're thinking we might need a cost-of-dispensing study. How does that look time frame?

DR. JOSEPH: A cost-of-dispensing fee survey depends on how we lay out the survey. I think the quickest that I've ever heard - we haven't done one, so, this is all from just reaching out to other states and speaking to others - but I think it takes at least three to six months.

Again, it really depends on how

we lay out the survey, what the requirements will be, is it mandatory, is it voluntary, who we're looking to target and, then, kind of setting up the time lines for an actual study. So, three to six months is my understanding.

MR. CARRICO: And if we send this through to mimic fee-for-service now, will this include immunizations in the meantime on the new formulary in January?

DR. JOSEPH: I'm confused. What do you mean, does it include immunizations?

MR. CARRICO: Like, if we said we want to mimic fee-for-service payments, will on January 15th I be able to bill for a pneumonia shot on Medicaid?

DR. JOSEPH: Through a managed care Medicaid member?

MR. CARRICO: Yes.

DR. JOSEPH: That's unchanging. So, the pharmacy benefit in its entirety from CMS is basically around covered outpatient drugs. So, this is what I believe everyone is writing their recommendations around.

The pieces around immunizations kind of falls off there because those aren't

technically covered outpatient drugs. So, we're not touching, we're not changing anything in terms of that coverage piece from the managed care side. So, we won't be doing anything there for 1/1.

MR. CARRICO: Okay.

MS. HUGHES: Now, Jessin, on the changes on how long it's going to take to implement these recommendations, it would require a reg change, correct?

DR. JOSEPH: Yes.

MS. HUGHES: So, you're looking at six to seven months for that to go through the regulatory process. Am I right there?

DR. JOSEPH: I think you're right, but I think we would do this as an emergency reg because there is a fiscal amount tied to it. We could check with Jonathan, though.

MS. HUGHES: Okay. I just wanted to point that out.

DR. JOSEPH: Yes. Definitely, it will have to go through all the regulatory processes.

MS. SMITH: I would just like to make a comment to kind of speak to what Jessin said, that if we mimic the fee-for-service methodology with

the exception, of course, of 340B because 340B's have protection already in Senate Bill 50, I think that's going to be an easy ask of our Medicaid Department because it's already in place; and if we start adding on at this point, I think we're going to get delay after delay.

So, I would like to keep my motion as it is and, then, have an additional motion or do a second motion that after we get this implemented, that we work together as a group on the other issues.

DR. JOSEPH: Is everybody aware of the lowest of logic within the Kentucky Medicaid fee-for-service program?

I know we've come to the conclusion but I just want to make sure everyone is aware of it because I know we've been referencing NADAC, and NADAC is something that would pay on a good chunk of time but there are other pieces that when we look at the methodology we're hitting those price points just as often.

So, I know you all are aware of it, but from a fee-for-service standpoint, I do want to make sure everyone is up to speed about what that methodology is.

DR. ALMETER: Let me move this around so people can see that Section 2 of the link I sent that has the lowest of logic listed. And that's the piece I wanted to clarify is that there's a separate section there - I think it's Section 5 or Section 4 - that says 340B ceiling price will be considered in the lowest of logic, and that's the one piece I wanted to make sure is excluded from this.

MS. STRAUB: I agree.

DR. ALMETER: I just wanted to make sure that's in the motion.

MS. SMITH: Could you send that to me, please? It's on the Chat. I think you sent it on the Chat. Oh, I'm sorry. I'm looking on my email.

DR. ALMETER: I'll tell you exactly what it should read because what it reads is not what you want, or what we wanted.

CHAIRMAN POOLE: All right. Tell me what it should read, then,

DR. ALMETER: Lowest of logic shall not include the 340B ceiling price, and I'm going to type it out right now.

CHAIRMAN POOLE: Are you all seeing my screen at all?

MS. SMITH: No.

CHAIRMAN POOLE: I'm trying to share it.

MS. HUGHES: Hit the green Share Screen and, then, you have to click on the document you're wanting to share.

CHAIRMAN POOLE: Okay. So, Philip, I'm not seeing what you're typing. So, if you want to just dictate it.

DR. ALMETER: I can tell you right now. The new recommendation should say for a 340B-purchased drug dispensed by a pharmacy, the lowest of logic shall not include the 340B ceiling price.

DR. JOSEPH: I'm only saying this, again, just out of semantics and what we're seeing here. The way that I read this is the PTAC is only giving us a recommendation for the dispensing fee.

MS. McCORMACK: So, it should say ingredient cost and dispensing fee rate in the first line, right?

DR. ALMETER: So, that second line, dispensing fee rate and ingredient cost. Is that what you're saying, Jill?

MS. McCORMACK: For our Kentucky DMS to request that CMS approve - I don't know if you have to say federally-recommended because CMS - I think we just need to say the NADAC plus the current fee-for-service dispensing fee or say ingredient cost, the current ingredient cost and dispensing fee methodology employed in the fee-for-service program, something along those lines.

CHAIRMAN POOLE: Well, but the problem is NADAC is not just it.

MS. McCORMACK: Oh, that's right. Okay. And, so, approve the federally-recommended fee-for-service ingredient cost and dispensing fee.

MS. SMITH: Right.

MS. McCORMACK: And dispensing fee rate as the floor for reimbursement for Kentucky Medicaid prescriptions filled under the managed care - managed care or fee-for-service for all pharmacy types including specialty and 340B. So, we want to take 340B out, right, because you don't want the lower of?

CHAIRMAN POOLE: Is that true, Philip?

DR. ALMETER: Can you say it one

more time?

MS. STRAUB: We need for it to be separate because it's not the lower.

CHAIRMAN POOLE: So, you want to put excluding 340B?

MS. STRAUB: Right, and, then, make sure that addendum is down there that they don't adhere to the lowest of logic, something like that.

MS. McCORMACK: And instead of saying included in this motion, you could say additionally - I'm just making it more concise - additionally, DMS should send request to CMS in a timely manner since Senate Bill 50 requires that the Cabinet set reimbursement rates to be used in conjunction with a single state MCO.

So, I think you just go to where it says, included in this motion, just say additionally because it will be included in the motion because this is the motion. Sorry. I have my little red pen out. Sorry, guys. I should have been a book editor instead of a lobbyist.

CHAIRMAN POOLE: So, included in the motion, what now?

MS. McCORMACK: Just make it, additionally, that DMS instead of saying included in

the motion.

MS. SMITH: Ron, where it says included - yeah, right there.

DR. ALMETER: I have something I need to comment on. Jessin, you tell me how accurate this is. My understanding is that federally, you're required to submit a 340B price when it comes to Medicaid fee-for-service.

So, you can't really say this. The recommendation for removing the ceiling price at a lowest logic really lives in the MCO world but not in the fee-for-service world. It has to stay in fee-for-service. We're required. There's no way around it. I know you're having to do all kinds of Jujutsu in this typing, Ron.

CHAIRMAN POOLE: Where do I need to go?

MS. STRAUB: I just think if you put fee-for-service, it's different from the managed care and it's confusing with 340B. Is that what you're saying, Philip?

DR. ALMETER: Yes. So, if you took out fee-for-service in that first, then, it's okay.

MR. CARRICO: Jessin, if we

wanted to address the issue that I brought up about just one dispensing fee per month, do we put this in here or is this something we address after CMS hopefully approves this?

DR. JOSEPH: The concern you brought up is much more of a plan benefit design issue. You could certainly put it in here, but that is less of what the rate is versus what Senate Bill 50 is telling what the PTAC to do in terms of rates versus how we operationalize that rate. I wouldn't say you can't. It just falls outside of what Senate Bill 50 was asking.

MR. CARRICO: So, if I wanted to address this, when would be the time, now or later?

DR. JOSEPH: I would say at the next PTAC meeting just because it's not on this agenda.

MR. CARRICO: Okay. And if we wanted----

DR. JOSEPH: You could send me the concern in an email and we could take a look at it.

My first thinking off the top of my head is for certain products, I think it may make sense; but if we were to remove this entirely,

then, we don't have a safeguard from a payor standpoint of pharmacists submitting a claim every day for a one-day supply, right?

MR. CARRICO: Correct, but now with the new NCPDP stuff that's getting submitted, you're able to see what the original quantity is and the quantity dispensed. So, I think you might be able to see if someone is gaming the system that way.

DR. JOSEPH: Right. That's true; but I think from our standpoint is do we want to even allow anybody to game the system versus setting up those safeguards up front as part of the plan benefit design but perhaps we shouldn't talk about that today.

MR. CARRICO: Okay. What about an appeal for ingredient cost?

DR. JOSEPH: Are you asking should you put that in here?

MR. CARRICO: Correct, or is that the next PTAC meeting as well?

DR. JOSEPH: Again, you can put it in here; but the way I read this is PTAC is recommending DMS go to the fee-for-service methodology and we would operationalize that the same way we operationalize the fee-for-service side.

So, if NADAC is too low, our instruction to pharmacists is to reach out to the NADAC administrators or CMS which will eventually lead you to Myers & Stauffer, but at that point, we're agreeing to use a nationally-priced benchmark. We don't have a state control over it.

MS. McCORMACK: Just something else for us to think about. If MAC is in the lower-of formula, how do we protect against everything just getting MAC'd and being the lower of?

CHAIRMAN POOLE: That's basically what Matt is talking about is that----

MS. McCORMACK: Okay. I'm sorry.

CHAIRMAN POOLE: ----what is our appeal or recourse or what action do we have because we all have lived in this world and know what can happen when prices get okayed to go ahead and low ball everything to where you're just going to be breaking even with the dispensing fee and not reimbursed anything on the cost.

MS. McCORMACK: So, did Jessin recommend that we put this on for our next meeting?

DR. JOSEPH: Yes, you certainly can. Again, how we would operationalize this the way

that it's written is more so that we would say if - (inaudible) MAC is severely low. We would instruct pharmacists to appeal the MAC through the appropriate channels. Again, the MAC is a little bit more easier of an appeal process than the NADAC because, again, the NADAC is going to be set by Myers & Stauffer and CMS versus the MAC being set by the Pharmacy Benefit Manager.

MS. McCORMACK: Right, but there's also ways that you can streamline the MAC process to make it more pharmacy friendly.

So, I'd like to continue that conversation after I have some time to look at maybe the mono lens that CMS may have around that and talk to some more folks that know a little bit more about this than me. So, whether we continue it today or at our next meeting, I'm fine.

DR. ALMETER: I have a quick comment. Just that very first sentence, can we remove excluding 340B pharmacies and all pharmacy types, period, because you really cover the 340B language in that last sentence.

MS. STRAUB: Yes. That's what I was going to say, because if you're reading it, it's like you're excluding 340B. So, yeah.

MR. CARRICO: I've got another question, I guess, back to what we were just speaking about. I thought Senate Bill 5 defined MAC in the State of Kentucky as however a generic drug is reimbursed, not maximum allowable cost. So, if that's the case, wouldn't even NADAC be able to be appealed in this scenario since it's through a PBM and not fee-for-service?

Is Shannon Stiglitz on this call? I thought she would have insight on this. No? All right. I guess I've got some research to do before our next meeting, then.

CHAIRMAN POOLE: Okay. Is everybody okay, first of all, with the primary motion and, then, any other motion unless somebody feels differently----

MS. STIGLITZ: I'm here. If you can hear me, this is Shannon Stiglitz.

CHAIRMAN POOLE: We can hear you, Shannon. Go right ahead.

MS. STIGLITZ: I don't know if I'm allowed to speak, Ron. That might be a Sharley question.

CHAIRMAN POOLE: Can she speak, being a registered lobbyist?

MS. HUGHES: I can't tell you who can speak and can't speak at the meeting.

CHAIRMAN POOLE: So, Shannon, enjoy yourself. Let's hear you.

MS. STIGLITZ: Well, a couple of things I would say is I would have concerns for pharmacies using the lowest of logic because it is including MAC. MAC as defined in KRS 304 which is in the Department of Insurance statutes, I don't know that that same MAC definition applies in Medicaid.

I would think that pharmacies would want NADAC to be the floor. And, then, if there is not a NADAC price, then, you would go lowest of logic on MAC, WAC, FUL, AMP, whatever is lower, but I think you have to be very careful that you include MAC in your lowest-of-logic ingredient cost. That's just my opinion.

MS. McCORMACK: I'm glad to hear from Shannon and I think she's right. Thank you, Shannon.

MR. CARRICO: I agree.

CHAIRMAN POOLE: So, how would you reword this, Shannon?

DR. JOSEPH: Shannon, I'm not going to tell you how to reword it. I would just

point out that if you do want to reference back to how CHFS has set up our regs, we do define MAC. So, that might be easier than somebody defining MAC for the first time.

MS. STIGLITZ: I mean, but does that MAC say that it can't be below all pharmacists' costs? I mean, the whole point of NADAC is that you're reimbursing at actual cost, or just say AAC is the lowest, is the floor if you don't want to say NADAC.

I mean, I don't know, but if you use the word MAC - and I don't know what the definition off the top of my head is in the DMS regulations - but, typically, and you're setting the reimbursement rates, Jessin. So, the ingredient cost, I mean, it just becomes arbitrary.

And, so, a pharmacy could be getting a $10.64 dispensing fee and getting reimbursed 10% of their cost of the ingredient. I think you have to have a floor that is more objective than MAC.

CHAIRMAN POOLE: This is what you said, Shannon. So, tell me your reasons why this is again better than ingredient cost.

MS. STIGLITZ: I mean, again, I

would say that MAC is more a term of art instead of a term of distinction or that's objective and measurable; but I would argue that for ingredient cost, NADAC shall serve as the floor, the lowest reimbursement possible, unless there is no NADAC price set and, then, you go to WAC, FUL, AMP, AAC - if you want to throw MAC in there, I'll leave that to you - the lowest of logic after that.

MS. SMITH: I think we're getting away from the State Plan fee-for-service - am I correct, Jessin - because it identifies ingredient cost as the lower logic. It has NADAC, WAC plus zero.

DR. JOSEPH: Again, guys, I'm not trying to tell you how to do this, but from an interpretation standpoint, I think what I'm hearing is that the fee-for-service ingredient cost methodology and instead of a MAC, the PTAC is recommending an actual acquisition cost.

DR. ALMETER: I don't know that that's what we're recommending.

MR. CARRICO: Because that would really mess up 340B.

DR. JOSEPH: I get that, but if we can exclude the 340B piece, I mean, take out 340B,

I think that's where the MAC, outside of 340B, you don't want a MAC. You want to at least make the pharmacist whole and you need an actual acquisition cost or no?

MR. CARRICO: As the floor.

DR. JOSEPH: As the floor, right. So, you say the ingredient cost, NADAC, FUL, I think it's ASP plus six, WAC. And, then, instead of a MAC, you want the bare minimum of the floor to be including an AAC because I think the concern is that the MAC could be too low, right?

MR. CARRICO: Correct. MAC has really bitten us in the rear end many times throughout the years, but I want to make sure that we're not setting 340B up for disaster if we use AAC or----

MS. STRAUB: Exactly. I don't think we need to use AAC at all.

DR. JOSEPH: Okay. So, then, I would say that you don't recommend the ingredient cost to be the same as the fee-for-service one because now we're not doing that.

DR. ALMETER: We took out fee-for-service language in here.

DR. JOSEPH: The first line, for

Kentucky DMS to request that CMS approve the federally-recommended fee-for-service.

MS. STRAUB: Yeah, we need to take out fee-for-service, top line.

MR. CARRICO: So, basically, we just need to take out MAC from the fee-for-service logic, correct?

DR. JOSEPH: That's what it sounds like to me.

DR. ALMETER: You could put after the 340B language there, MAC is to be excluded from the lowest of logic.

MS. STRAUB: Yes. Yes.

DR. ALMETER: Then, all you have is NADAC, WAC, federal upper limit and usual and customary.

MS. McCORMACK: Wouldn't it be easier, maybe it doesn't make any sense, would it just be easier to not type the fee-for-service, just say the managed care rate should be "x" and not to do the exceptions, or am I missing something?

MR. CARRICO: I think we're all saying the same thing.

MS. STRAUB: Yes, but we're saying it a different way.

DR. ALMETER: And just for the record, for Ron, I might put it in a separate sentence. It would be very difficult to tie it into one sentence.

DR. JOSEPH: The other thing I would take out is the federally-recommended part.

DR. ALMETER: So, that last sentence, before you get to taking out MAC, 340B drugs dispensed by a pharmacy should not be included in the 340B ceiling price. So, you could take out MAC and, then, add a sentence on the end that says MAC will not be included in the lowest of logic.

MS. STRAUB: Correct.

DR. ALMETER: And you could also take out at the beginning of the 340B to just take out for and of. You could just start with 340B.

MS. SMITH: I think we have to put the dispensing fee rate in because we don't have that now, right, because we were referring back to the fee-for-service?

MS. STRAUB: Yes, we'll have to add that since we took out the service model.

MS. SMITH: The second line, dispensing fee rate of $10.64 on the second line as the floor.

CHAIRMAN POOLE: Is silence a good thing?

MS. SMITH: We're reading. We're making sure that everything is covered. I really think what we added with the 340B in red needs to go up. The additionally, that sentence needs to be last. Does that make any difference? It just reads better.

DR. ALMETER: Yes. That makes sense.

MR. CARRICO: On the third motion, do we need to add compounding as well?

CHAIRMAN POOLE: Well, what I was going to do, all these other motions down here, unless Jessin tells us different, we can work on these later or would you rather go ahead and put them in now?

MR. CARRICO: I guess, Jessin, if we went forward with how that one is worded, how is specialty and compounding going to be reimbursed in the meantime? Are they going to make just $10.64 scripts, period?

DR. JOSEPH: That's how I'm reading the recommendation.

CHAIRMAN POOLE: Yes.

MR. CARRICO: And how does fee-for-service currently do it for specialty and/or compounding?

DR. JOSEPH: Ten sixty-four.

MR. ALMETER: Ten sixty-four.

MS. SMITH: Ron, it needs to say single state PBM, not MCO. Thanks. I'm comfortable with that motion.

MS. STRAUB: I second.

CHAIRMAN POOLE: So, for officialness here, Rosemary, would you like to state your original motion?

MS. SMITH: Yes, I will. For our Kentucky DMS to request that CMS approve the ingredient cost as NADAC, FUL, WAC, U&C and dispensing fee rate of $10.64 as the floor for reimbursement for Kentucky Medicaid prescriptions filled under managed care and all pharmacy types.

340B-purchased drugs dispensed by a pharmacy should not be included as a 340B ceiling price. MAC will not be included in the lowest of logic.

Additionally, that DMS send a request to CMS in a timely manner since Senate Bill 50 requires that the Cabinet sets reimbursement rates

to be used in conjunction with a single state PBM.

DR. ALMETER: So, there's one edit and I'm sorry. 340B-purchased drugs dispensed by a pharmacy should not have the 340B ceiling price included in lowest of logic. That's how it should read.

MS. SMITH: Yes. That sounds good. I agree with that.

MS. McCORMACK: I think it should be included in lowest of logic, right? Sorry. I've got my red pen out again but I may be wrong.

DR. ALMETER: Yes.

MS. SMITH: Yes. Jill, we're making you our Editor-in-Chief.

DR. FIGG: Ron, do we need to include in that first sentence reference to the lowest, like, when NADAC is not available? Like, we just kind of lumped all that together. Is that reading okay?

CHAIRMAN POOLE: My head is kind of spinning right now.

MS. McCORMACK: Let's ask Jessin. Jessin, does that first sentence, does that make sense or not? Is that doing what it we want it to or is it not?

DR. JOSEPH: I mean, I know what you guys are talking about, but I think from a formal standpoint, what we might want to put in, and since you reference a lowest of logic in red at the end of that sentence, you might want to say, for Kentucky DMS request that CMS approve the lowest-of-logic ingredient cost as. That way, then, we know that we're talking about a lowest of logic here, not one or the other.

MS. McCORMACK: Thank you.

MS. SMITH: Meredith, does that answer your question?

DR. FIGG: Yes. I think so. It was just confusing to me on when we were going to use which one. We just kind of threw them all in that first sentence.

MS. SMITH: Jessin, does that look okay now?

DR. JOSEPH: Yes. I feel like I understood it.

MS. SMITH: Shall I read it again?

CHAIRMAN POOLE: Read it again, please.

MS. SMITH: For our Kentucky

DMS to request that CMS approve the lowest-of-logic ingredient cost as NADAC, FUL, WAC, U&C and dispensing fee rate of $10.64 as the floor for reimbursement for Kentucky Medicaid prescriptions filled under managed care and all pharmacy types.

340B-purchased drugs dispensed by a pharmacy should not have the 340B ceiling price included in lowest of logic. MAC will not be included in the lowest of logic.

Additionally, that DMS send request to CMS in a timely manner since Senate Bill 50 requires that the Cabinet sets reimbursement rates to be used in conjunction with a single state PBM.

CHAIRMAN POOLE: Motion by Rosemary.

MR. CARRICO: Second.

CHAIRMAN POOLE: Second by Matt. Any further discussion? All those in favor, say aye. Any opposed? This officially is the longest motion that I've ever worked with and that's saying something for being on the Board of Pharmacy.

MR. CARRICO: Ron, you did a great job as the stenographer.

CHAIRMAN POOLE: Do we want to pursue any of the secondary motions at this time or

do we want to do some research?

I don't think the second motion or the third motion would be a problem. Certainly coming up with an appeal process to help Jessin and his people out with - I mean, just by saying, yeah, we need an appeal process. Well, that's all fine and good, but we probably just need to have some discussions on that for next time.

MS. McCORMACK: I would say let's vote on the second and third motion and hold the fourth motion for the next meeting.

CHAIRMAN POOLE: Okay.

MR. CARRICO: I guess I've got one question. Jessin, if this goes the way it is, say this started March 1st or whatever, under the way this is, we'll be able to bill for immunizations, correct?

DR. JOSEPH: Yes. So, if this goes the way it is, I don't see how this impacts immunizations in any way under the managed care benefit.

MR. CARRICO: Okay. Just making sure because we've got to order our shots for next year in about a month and a half.

DR. JOSEPH: I don't want to be

overly cautious. I mean, I know what you guys are talking about. So, I'm not necessarily worried about conveying this message to my team here, but if you want to be overly cautious here, you can say for covered outpatient drugs or you could say excluding immunizations but I really don't think you need to do that, to be honest.

MR. CARRICO: Okay. So, with this motion that we have, what is the time line of when you think it will be submitted to CMS for approval?

DR. JOSEPH: Since this is a recommendation to the Department, I have to take this up to my leadership and, then, I'm sure the Secretary will be involved and, then, I'll know next steps, but I can't necessarily say that we're going to submit this to CMS tomorrow or anything.

MR. CARRICO: I guess when will we hear what the next step is if they say that's a good motion or recommendation?

DR. JOSEPH: I can put it on everyone's agenda as soon as this is finalized and sent over and we can push to have a response; but in terms of, again, a time line, I can't commit to anything.

CHAIRMAN POOLE: Does anybody care to make a motion on the second one there?

DR. ALMETER: I motion.

MS. STRAUB: My only concern is doesn't the second motion have to do with provider status, and I don't know, can you do that under Medicaid?

DR. ALMETER: Well, when you say develop clinical protocols----

MS. STRAUB: So - okay.

DR. ALMETER: Correct me if I'm wrong because I've not been as involved in the legislation, but I think it's always been a hard no when we talk about provider status, but when you talk about reimbursed----

MS. STRAUB: Right.

DR. ALMETER: ----in circles as we do, you get more traction. This seems more about services that was provided.

MS. STRAUB: Okay. Good. That's good.

DR. ALMETER: I mean, I'm open to feedback.

MS. STRAUB: Okay. I want to make sure. Okay.

DR. ALMETER: Because the word provider is really not in that.

MS. STRAUB: Okay. Good.

CHAIRMAN POOLE: So, we have a motion by Philip.

MS. SMITH: Second.

CHAIRMAN POOLE: And a second by Rosemary. Any further discussion? All those in favor, say aye. Any opposed? We're getting much faster. I'm just kidding you all, too. I just want to get this right and I know you all do, too.

At this time, do we want to develop that third motion or do you feel we've got enough time at the next meeting to work on that one?

DR. FIGG: Ron, I think I might have some more information I could look at on at least specialty. So, if I'm not going to hold the group up, I'd say put this on the agenda for the next meeting so we have some time to go back and do some research.

CHAIRMAN POOLE: Okay.

DR. FIGG: But I'll defer to others if----

CHAIRMAN POOLE: Can everybody else - I didn't mean to cut you off, Jill. You all

can also be thinking about any type of appeal process suggestion. I personally would like to define it as much as we can to help out our Department because just saying, hey, we need an appeal process, well, okay, what. So, just be thinking about those, especially those of us who have been in the trenches of appeal processes for a long time.

With that being said, is there anything else? We've pretty well covered our main objectives. I'll be getting in touch with you guys about a date in the future.

DR. JOSEPH: Ron, I'm sorry, and Sharley is on. So, are these recommendations going to the MAC first?

CHAIRMAN POOLE: That's the appropriate way of doing it. Do you know when the full MAC meeting is, Sharley or Jessin?

MS. HUGHES: Let me look. It's November 19th.

CHAIRMAN POOLE: Okay. Great. And I'm assuming it's a virtual meeting also?

MS. HUGHES: Yes, it will be, and someone from the TAC will need to present the recommendations.

CHAIRMAN POOLE: Okay. I'll

just be in touch with all of you. I don't think November 19th should be a problem for me to submit this to them. So, Sharley, just let me know on the date and time and I'll make sure that me and somebody else on the PTAC here will be present to present that.

MS. HUGHES: It's from 10 to 12:30 is the time on there, and the link should be out on the MAC website within a week.

CHAIRMAN POOLE: Okay. Anything else? If not, I will accept a motion to adjourn.

MS. McCORMACK: I'll make the motion.

DR. ALMETER: Second.

CHAIRMAN POOLE: All those in favor, say aye. Thank you all.

MEETING ADJOURNED